APPLICATION
CERTIFIED CLINICAL SUPERVISOR

Please type or print in ink.

1. Name: _____
(As you wish it to appear on your certificate)

2. Home Address: _____

3. Home Phone: _____
Street/P.O. Box

_____
City/State/Zip Code

4. Email: _____

5. Social Security Number: _____

6. What language(s) are you fluent in other than English? _____

7. What is your ethnicity? (Optional -- research purposes only)

___	(1) Alaskan Native	___	(14) Micronesian
___	(2) American Indian	___	(15) Samoan
___	(3) Cambodian	___	(16) Tongan
___	(4) Chinese	___	(17) Other Pacific Isle
___	(5) Filipino	___	(18) African American
___	(6) Japanese	___	(19) Caucasian
___	(7) Korean	___	(20) Portuguese
___	(8) Laotian	___	(21) Cuban
___	(9) Okinawan	___	(22) Mexican
___	(10) Other Asian	___	(23) Puerto Rican
___	(11) Fijian	___	(24) Other Hispanic
___	(12) Hawaiian	___	(25) Mixed
___	(13) Part Hawaiian	___	(26) Other Specify

FOR OFFICIAL USE ONLY

Fee Amount:	_____	Transcripts:	_____
Date Received:	_____	Supervisor Forms:	_____
		Code of Ethics:	_____
DBASE:	_____	Background Check:	_____

CERTIFICATION/EDUCATION INFORMATION

I am a certified (check all that apply):

- ☐ Certified Substance Abuse Counselor (CSAC)
- ☐ Certified Criminal Justice Addiction Professional (CCJP)
- ☐ Certified Co-Occurring Disorder Professional (CCDP)
- ☐ Special substance abuse credential in another professional discipline in the human services field at the master's level or higher.

I have requested that official transcripts be sent to ADAD: YES NO

EDUCATION (must be documented by an official transcript and/or copies of certificates of completion)

Type of Behavioral Science Degree: _____

Clinical Supervision Domains:
(Minimum of thirty hours with at least four hours in each domain)

Counselor Development: ..... _____ hours

Professional and Ethical Standards: ..... _____ hours

Program Development & Quality Assurance: ..... _____ hours

Program Evaluation: ..... _____ hours

Administration: ..... _____ hours

Treatment Knowledge: ..... _____ hours

TOTAL: _____ (minimum of 30 hours)

SUPERVISORY WORK HISTORY

Work history must be verified through the enclosed Work Experience Verification Record.

NOTE: A copy of your resume may substitute for this work history.

Start with your present employer, or if unemployed, your last employer and list your employment record in **REVERSE CHRONOLOGICAL** order. You must provide sufficient information to clearly document alcohol and other drug counseling supervisory work experience. You may attach job descriptions or other relevant materials to provide further clarification. **INFORMATION WHICH CANNOT BE VERIFIED WILL NOT BE ACCEPTED**.

Indicate your employment status for each position as full-time (40 hours or more per week); part-time (less than 40 hours per week); Intern (position within a structured training program); or volunteer

(unpaid position). **IF YOU ARE WORKING AS A VOLUNTEER, YOU MUST ATTACH A JOB DESCRIPTION**

EMPLOYER:	**DATES OF EMPLOYMENT:** **FROM:** **TO:**
EMPLOYER'S ADDRESS:	**AVERAGE NUMBER OF HOURS WORKED PER WEEK:**
SUPERVISOR'S NAME:	**SUPERVISOR'S PHONE NUMBER:**
EMPLOYMENT STATUS, DUTIES & RESPONSIBILITIES: **EMPLOYER:**	**PERCENT OF YOUR TIME SPENT IN PROVIDING SUPERVISORY WORK:**

EMPLOYER:	**DATES OF EMPLOYMENT:** **FROM:** **TO:**
EMPLOYER'S ADDRESS:	**AVERAGE NUMBER OF HOURS WORKED PER WEEK:**
SUPERVISOR'S NAME:	**SUPERVISOR'S PHONE NUMBER:**
EMPLOYMENT STATUS, DUTIES & RESPONSIBILITIES: **EMPLOYER:**	**PERCENT OF YOUR TIME SPENT IN PROVIDING SUPERVISORY WORK:**

This form may be reproduced, as needed, to complete your work history.

Have you at any time, been the subject of a finding of unethical, unprofessional, or illegal conduct made as part of a final decision by a regulatory body (e.g. certification or licensing board) or by a court (civil or criminal)?

_____YES _____No (If yes, attach an explanation and copies of official documents.)

"I hereby certify that all of the information given herein and on any attachment is true and complete to the best of my knowledge. I also authorize any necessary investigations and the release of personal information to the Alcohol and Drug Abuse Division (ADAD). I understand that falsification of any portion of this application or attachments may result in the revocation of this application.

I further agree to hold the Department of Health, Alcohol and Drug Abuse Division agents, staff and examiners free from any civil liability for damages or complaints about any action within the scope and arising out of the performance of their duties and which is taken in connection with this application, the examinations, grades received on examinations, and/or the failure of the Division to issue me a certificate."

_____

Applicant's Name (PRINT IN INK)

_____ _____

Applicant's Signature (SIGN IN INK) Date

** You must sign the "Code of Ethics Statement" which is included in this packet. Unsigned or incomplete applications will not be processed.

RECORD STORAGE

The Alcohol and Drug Abuse Division maintains records on all applicants for Certified Clinical Supervisor. Inactive records are archived for three (3) years from date of last correspondence and may be destroyed after three (3) years from the date of last correspondence. Therefore, it is important to keep ADAD informed of any address change.